



## Complete Summary

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### GUIDELINE TITLE

Depression in older adults.

### BIBLIOGRAPHIC SOURCE(S)

Kurlowicz LH. Depression in older adults. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 185-206. [33 references]

### GUIDELINE STATUS

This is the current release of the guideline.

## \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

On July 1, 2005, in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory to update patients and healthcare providers with the latest information on this subject. Even before the publication of these recent reports, FDA had already begun the process of reviewing available data to determine whether there is an increased risk of suicidal behavior in adults taking antidepressants. The Agency has asked manufacturers to provide information from their trials using an approach similar to that used in the evaluation of the risk of suicidal behavior in the pediatric population taking antidepressants. This effort will involve hundreds of clinical trials and may take more than a year to complete. See the [FDA Web site](#) for more information.

## COMPLETE SUMMARY CONTENT

### \*\* REGULATORY ALERT \*\*

#### SCOPE

#### METHODOLOGY - including Rating Scheme and Cost Analysis

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#### IMPLEMENTATION OF THE GUIDELINE

#### INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES  
IDENTIFYING INFORMATION AND AVAILABILITY  
DISCLAIMER

## SCOPE

### DISEASE/CONDITION(S)

Depression

### GUIDELINE CATEGORY

Evaluation  
Management  
Risk Assessment  
Treatment

### CLINICAL SPECIALTY

Geriatrics  
Internal Medicine  
Nursing  
Psychiatry

### INTENDED USERS

Advanced Practice Nurses  
Allied Health Personnel  
Nurses  
Pharmacists  
Physician Assistants  
Physicians  
Social Workers  
Utilization Management

### GUIDELINE OBJECTIVE(S)

- To present an overview of depression in older patients, with emphasis on age-related assessment considerations, clinical decision-making, and nursing intervention strategies for elders with depression
- To provide a standard of practice protocol for use by nurses in practice settings
- To discuss the consequences of late-life depression
- To identify nursing strategies for older adults with depression
- To discuss the major risk factors for late-life depression
- To identify the core competencies of a systematic nursing assessment for depression with older adults

### TARGET POPULATION

Hospitalized older adults

## INTERVENTIONS AND PRACTICES CONSIDERED

### Risk Assessment/Prognosis

1. Individualized depression assessment and interview
  - Review medical/social history
  - Assess for presence of risk factors
  - Ask direct questions regarding symptoms of depression, suicidal ideation, psychosis, recent losses or crises
  - Review medications
  - Assess cognitive dysfunction and functional disability
2. Standardized assessment tool (e.g., Geriatric Depression Scale-Short Form)

### Treatment/Management

1. Refer/consult mental health services as indicated
2. Incorporate psychosocial and behavioral nursing interventions into individualized care plan, including:
  - Safety precautions
  - Promotion of nutrition, elimination, sleep/rest patterns, physical comfort, and pain control
  - Relaxation strategies
  - Daily activity schedule
3. Refer to physical, occupational, and recreation therapies to encourage mobilization
4. Identify, mobilize, or designate a support person such as family, a confidant, friends, volunteers or other hospital resources, church member, support groups, patient or peer visitors, and appropriate clergy for spiritual support
5. Maximize autonomy, personal control, self-efficacy, and decision making about clinical care, daily schedules, and personal routines
  - Graded task assignment
  - Participation in regular, predictable pleasant activities
  - Pleasant events inventory
  - Music therapy
  - Pleasant reminiscences
  - Photographs, old magazines, scrapbooks
6. Provide emotional support through:
  - Empathetic, supportive listening
  - Encouraging patients to express their feelings in a focused manner on issues such as grief or role transition
  - Supporting adaptive coping strategies
  - Identifying and reinforcing strengths and capabilities
  - Maintaining privacy and respect
  - Instilling hope
7. Monitor
  - Therapeutic response to medication
  - Potential side effects of medication
8. Provide patient/family education

## MAJOR OUTCOMES CONSIDERED

- Prevalence of depression among older adults

- Symptomatic presentation
- Adverse effects of depression (physical, psychosocial, and behavioral functioning)
- Mortality/suicide associated with depression among older adults
- Percentage of older adults receiving services for primary psychiatric disorders, including depression
- Validity of Geriatric Depression Scale-Short Form
- Effectiveness of treatment (e.g., pharmacotherapy, psychosocial therapies)
- Effectiveness of nursing interventions
- Recurrence rate

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline was the database used.

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

### METHODS USED TO ANALYZE THE EVIDENCE

Review

### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

External Peer Review  
Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

# RECOMMENDATIONS

## MAJOR RECOMMENDATIONS

### Assessment Parameters

- Identify risk factors/high risk groups:
  - Current alcohol /substance use disorder
  - Specific comorbid conditions (dementia, stroke, cancer, arthritis, hip fracture, myocardial infarction, chronic obstructive pulmonary disease, and Parkinson's disease)
  - Functional disability (especially new functional loss)
  - Widows/widowers
  - Caregivers
  - Social isolation/absence of social support
- Assess all at-risk groups using a standardized depression screening tool and documentation score. The Geriatric Depression Scale-Short Form (GDS-SF) is recommended because it takes approximately 5 minutes to administer, has been validated and extensively used with medically ill older adults, and includes few somatic items that may be confounded with physical illness.
- Perform a focused depression assessment on all at-risk groups and document results. Note the number of symptoms; onset; frequency/patterns; duration (especially 2 weeks); changes in normal mood, behavior and functioning.
  - Depressive symptoms:
    - Depressed or irritable mood, frequent crying
    - Loss of interest, pleasure (in family, friends, hobbies, sex)
    - Weight loss or gain (especially loss)
    - Sleep disturbance (especially insomnia)
    - Fatigue/loss of energy
    - Psychomotor slowing/agitation
    - Diminished concentration

- Feelings of worthlessness/guilt
  - Suicidal thoughts or attempts; hopelessness
- Psychosis (i.e., delusional/paranoid thoughts, hallucinations)
- History of depression; current substance abuse (especially alcohol); previous coping style
- Recent losses or crises (e.g., death of spouse, friend, pet; retirement; anniversary dates; move to another residence or nursing home); changes in physical health status, relationships, or roles
- In elderly persons, frequent somatic (physical) complaints may actually represent an underlying depression
- Obtain/review medical history and physical/neurological examination.
- Assess for depressogenic medications (e.g., steroids, narcotics, sedatives/hypnotics, benzodiazepines, antihypertensives, histamine-2 antagonists, beta-blockers, antipsychotics, immunosuppressives, cytotoxic agents).
- Assess for related systematic and metabolic processes (e.g., infection, anemia, hypothyroidism or hyperthyroidism, hyponatremia, hypercalcemia, hypoglycemia, congestive heart failure, and kidney failure).
- Assess for cognitive dysfunction.
- Assess level of functional disability.

#### Care Parameters

- For severe depression (GDS score 11 or greater, 5 to 9 depressive symptoms [must include depressed mood or loss of pleasure] plus other positive responses on individualized assessment [especially suicidal thoughts or psychosis and comorbid substance abuse]), refer for psychiatric evaluation. Treatment options may include medication or cognitive-behavioral, interpersonal, or brief psychodynamic psychotherapy/counseling (individual, group, family), hospitalization, or electroconvulsive therapy.
- For less severe depression (GDS score 6 to 10, fewer than five depressive symptoms, plus other positive responses on individualized assessment), refer to mental health services for psychotherapy/counseling (see above types), especially for specific issues identified in individualized assessment and to determine whether medication therapy may be warranted. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community and institution-specific mental health services. If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made.
- For all levels of depression, develop an individualized plan integrating the following nursing interventions:
  - Institute safety precautions for suicide risk as per institutional policy (in outpatient settings, ensure continuous surveillance of the patient while obtaining an emergency psychiatric evaluation and disposition).
  - Remove or control etiologic agents.
    - Avoid/remove/change depressogenic medications.
    - Correct/treat metabolic/systemic disturbances.
  - Monitor and promote nutrition, elimination, sleep/rest patterns, and physical comfort (especially pain control).

- Enhance physical function (i.e., structure regular exercise/activity; refer to physical, occupational, recreational therapies); develop a daily activity schedule.
- Enhance social support (i.e., identify/mobilize a support person(s) [e.g., family, confidant, friends, hospital resources, support groups, patient visitors]); ascertain need for spiritual support and contact appropriate clergy.
- Maximize autonomy/personal control/self-efficacy (e.g., include patient in active participation in making daily schedules and setting short-term goals).
- Identify and reinforce strengths and capabilities.
- Structure and encourage daily participation in relaxation therapies, pleasant activities (conduct a pleasant activity inventory), and music therapy.
- Monitor and document responses to medication and other therapies; readminister depression screening tool.
- Provide practical assistance; assist with problem-solving.
- Provide emotional support (i.e., empathic, supportive listening; encourage expression of feelings and hope instillation), support adaptive coping, and encourage pleasant reminiscences.
- Provide information about the physical illness and treatment(s) and about depression (i.e., that depression is common, treatable, and not the person's fault).
- Educate about the importance of adherence to prescribed treatment regimen for depression (especially medication) to prevent recurrence; educate about specific antidepressant side effects due to personal inadequacies.
- Ensure mental health community linkup; consider psychiatric, nursing home care intervention.

#### Follow-up to Monitor Condition

- Continue to track prevalence and documentation of depression in at-risk groups.
- Show evidence of transfer of information to postdischarge mental health service delivery system.
- Educate caregivers to continue assessment processes.

#### CLINICAL ALGORITHM(S)

None provided

### EVIDENCE SUPPORTING THE RECOMMENDATIONS

#### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

#### Patient Will Demonstrate:

- Personal safety
- Evaluation by psychiatric services for severe depression
- Reduction of symptoms indicative of depression (e.g., reduction in the Geriatric Depression Scale (GDS) score and resolution of suicidal thoughts or psychosis
- Improved daily functioning

#### Health Care Provider Will Demonstrate:

- Early recognition of patient at risk, referral, and interventions for depression
- Improved documentation of outcomes

#### Institution Will Demonstrate:

- Increased number of patients identified with depression
- No increase in the number of in-hospital suicide attempts
- Increased referrals to mental health services
- Increased referrals to psychiatric nursing home care services
- Improved staff education on depression recognition, assessment, and interventions

### POTENTIAL HARMS

Not stated

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better

### IOM DOMAIN

Effectiveness  
Patient-centeredness



## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Kurlowicz LH. Depression in older adults. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 185-206. [33 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2003

### GUIDELINE DEVELOPER(S)

The John A. Hartford Foundation Institute for Geriatric Nursing - Academic Institution

### GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

### SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

### GUIDELINE COMMITTEE

Not stated

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Author: Lenore H. Kurlowicz, PhD, RN, CS and NICHE Faculty; Assistant Professor of Geropsychiatric Nursing, School of Nursing, University of Pennsylvania

### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

### GUIDELINE STATUS

This is the current release of the guideline.

## GUIDELINE AVAILABILITY

Copies of the book Geriatric Nursing Protocols for Best Practice, 2nd edition:  
Available from Springer Publishing Company, 536 Broadway, New York, NY  
10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web:  
[www.springerpub.com](http://www.springerpub.com).

## AVAILABILITY OF COMPANION DOCUMENTS

None available

## PATIENT RESOURCES

None available

## NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 26, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications.

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